Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PO BOX 700311
SAN ANTONIO TX 78224

COMBINED CHIROPRACTIC SERVICES &
REHABILITATION, INC.

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-2617-01

MFDR Date Received

MARCH 22, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated March 30, 2011: "The following is a brief letter regarding dispute of an upper extremity EMG/NCV performed on patient…It has come to my attention that the carrier has the position of not reimbursing for this procedure. The patient had not had an upper extremity EMG/NCV performed in her case. Preauthorization was not necessary for this patient to have any upper extremity EMG/NCV. What was important was that this patient needed medical necessity concerns. History clearly shows that the patient had significant injuries to the right wrist, right shoulder, and cervical spine."

Amount in Dispute: $2165.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual denied the services as the health care provider who provided or supervised the services must submit his or her own bill. Block 31 of the CMS-1500 indicates that Carey Davis, D.C. performed the services. However, the supporting documentation shows that Meyer Proler, M.D. performed the professional component and Dr. Davis performed the technical component only. The requestor is seeking reimbursement for the whole procedure." "As Dr. David did not perform the whole procedure, he may only bill for the technical component. The CMS-1500s submitted by the requestor were missing the TC modifier indicating the bill was for the technical component only."

Response Submitted by: Texas Mutual Insurance Co., 6210 East Hwy. 290, Austin, TX 78723-1098

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 16, 2010	CPT Code 95900-59 (6) - Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study	$690.00	$0.00
	CPT Code 95903-59 (4) - Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study	$460.00	$0.00
July 16, 2010	CPT Code 95904-59 (6) - Nerve conduction, amplitude and latency/velocity study, each nerve; sensory	$690.00	$0.00

	CPT Code 95861 - Needle electromyography; 2 extremities with or without related paraspinal areas	$250.00	$0.00
	HCPCS Code A4556 (6) - Electrodes (e.g., apnea monitor), per pair	$30.00	$0.00
	HCPCS Code A4215 - Needle, sterile, any size, each	$5.00	$0.00
	HCPCS Code A4558 - Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz	$5.00	$0.00
	CPT Code 99211-25 - Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.	$35.00	$0.00
TOTAL		$2165.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services
4. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the procedure for submitting medical bills.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated September 22, 2010
   - Per Rule 180.24, financial disclosure not met. Direct supervision by a licensed physician/health care provider lacking as represented on bill. Purported supervision by a licensed physician/health care provider was not of an employee. The health care provider who provided or supervised the services must submit his or her own bill.
   - 892-Per DWC Rules 133.10, 133.20 and clean claim guide instructions for completing the CMS-1500 professional license type, number and jurisdiction of the individual HCP who rendered the health care is required.
   - 896-Statutory/Regulatory violation.
   - B7-This provider was not certified/eligible to be paid for this procedure/service on this date of service.
   - 892-Denied in accordance with DWC rules and/or medical fee guideline
   - CAC-W1-Workers' compensation state fee schedule adjustment.
   - 783-Comparison studies of non-compensable side are not reimbursed. Only allowed if compensable injury affects both extremities.
   - CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised or either the remittance advice remark code or NCPDP reject reason code).
   - CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 732-Accurate coding is essential for reimbursement. CPT and/or modifier billed incorrectly. Services are not reimbursable as billed.
   - 762-Denied in accordance with 134.600(p)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.

Explanation of benefits dated February 23, 2011

- 891-No additional payment after reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- Per Rule 180.24, financial disclosure not met. Direct supervision by a licensed physician/health care provider lacking as represented on bill. Purported supervision by a licensed physician/health care provider was not of an employee. The health care provider who provided or supervised the services must submit his or her own bill.
- 892-Per DWC Rules 133.10, 133.20 and clean claim guide instructions for completing the CMS-1500 professional license type, number and jurisdiction of the individual HCP who rendered the health care is required.
- 896-Statutory/Regulatory violation.
- B7-This provider was not certified/eligible to be paid for this procedure/service on this date of service.
- 892-Denied in accordance with DWC rules and/or medical fee guideline
- CAC-W1-Workers' compensation state fee schedule adjustment.
- 783-Comparison studies of non-compensable side are not reimbursed. Only allowed if compensable injury affects both extremities.
- CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised or either the remittance advice remark code or NCPDP reject reason code).
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
- CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 217-The value of this procedure is included in the value of another procedure performed on this date.
- 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 732-Accurate coding is essential for reimbursement. CPT and/or modifier billed incorrectly. Services are not reimbursable as billed.
- 762-Denied in accordance with 134.600(p)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules.

Issues

1. Does the documentation support the level of service billed for CPT codes 95900, 95903, 95904, 95861?
2. Are HCPCS codes A4556, A4215 and A4558 included in another service/procedure billed on July 16, 2010?
3. Does the documentation support a separate identifiable Evaluation and Management service? Is the requestor entitled to reimbursement for CPT code 99211-25?

Findings

1. According to the explanation of benefits, CPT codes 95900, 95904, 95903 and 95861 were denied reimbursement based upon reason code "225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information"; and "CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised or either the remittance advice remark code or NCPDP reject reason code)".

   A review of the submitted documentation indicates that the July 16, 2010 nerve studies interpretation report was signed by Meyer Proler, MD from Interpreting Physicians Link.

   The July 16, 2010 NeuroDynamics report is unsigned and does not identify the healthcare provider that performed the testing.

   A review of the submitted medical bill indicates that Cary Davis DC billed for the whole procedure. The documentation does not support that Dr. Davis performed the whole procedure for the disputed services. Therefore, the documentation does not support the level of service billed. As a result, reimbursement is not recommended.

2. The respondent denied reimbursement for HCPCS codes A4556, A4215 and A4558 based upon reason codes "CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated"; and "217-The value of this procedure is included in the value of another procedure performed on this date".

Per Medicare rules HCPCS codes A4556 and A4558 are bundled codes and payment allowance is included in another service; therefore, reimbursement is not recommended.

Per Medicare rules HCPCS code A4215 is not covered by Medicare in any payment system; therefore, reimbursement is not recommended.

3. According to the explanation of benefits the respondent denied reimbursement for the office visit, CPT code 99211, based upon reason codes "790-This charge was reimbursed in accordance to the Texas medical fee guideline"; and "CAC-W1-Workers' compensation state fee schedule adjustment".

   Dr. Davis appended modifier 25 to code 99211 to identify a significant, separate evaluation and management service.

   Modifier 25 is defined as "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service."

   A review of the submitted documentation finds that Dr. Davis did not submit a copy of the office visit report to support billing of CPT code 99211-25; therefore, the documentation does not support a significant, separate evaluation and management service. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		7/6/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.